IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
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E-mail: fsb@idhw.state.id.us

August 15, 2008

Teresa Carpenter
Preferred Community Homes Cornerstone
615 2nd Avenue West
Wendell, Idaho 83355

RE: Preferred Community Homes Cornerstone, Provider #13G056

Dear Ms. Carpenter:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes Cornerstone, which was conducted on July 31, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 27, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by August 27, 2008. If a request for informal dispute resolution is received after August 27, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

PRINTED: 08/14/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey. The surveyors conducting the survey were: Michael Case, LSW, QMRP, Team Leader Matt Hauser, QMRP Common abbreviations used in this report are: HRC - Human Rights Committee IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse PRN - As Needed QMRP - Qualified Mental Retardation Professional	W 000	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Cornerstone with the facts, findings or other statements as alleged by the state agency dated July 31st, 2008. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Cornerstone – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure all information was kept confidential for 6 of 6 individuals (Individuals #1- #6) whose names were posted with their diet requirements and adaptive equipment schedule in a common area of the facility. This resulted in individuals' information being available to any visitors (individuals' guardians, family, friends, repairmen, etc.) in the facility. The findings include: During observations on 7/28/08 from 5:15 - 6:10 p.m., and 7/29/08 from 6:45 - 8:05 a.m. and 3:20 - 4:20 p.m., a document titled "[Facility name] Diets and Assistive Equipment," undated, was	W 112	**W 112 483.410(c)(2) CLIENT RECORDS** The facility will keep all client information in a binder for staff to review. No information regarding clients will be posted in the facility. The Administrator will check the facility every A.M. Monday thru Friday while doing her rounds, to ensure the deficient will not recur. To be completed by the Administrator By 10/03/08.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Carpenter	Admin	8/25/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 112	Continued From page 1 noted to be posted on the refrigerator in the kitchen near the dining room doorway. The document identified each individual by their first name and included the following information: "[Individual #4] - Mechanical soft regular diet with ensure [sic] 4 ounces with meals, carnation instant breakfast [sic] with 8 ounces whole milk @ 10 AM daily. Offer 8 ounces of ensure [sic] when refuses meals. [Individual #4] needs as many fluids as tolerated. Inner lip plate, small spoon, nosy glass. [Individual #2] - Regular mechanical soft diet with 1 1/2 portions, offer ensure [sic] for less than 50% of meal. Dietician recommends to increase fiber intake. NO APRICOTS [sic] Inner lip plate, small spoon, wrist splint, nosy cup. [Individual #6] - Regular mechanical soft diet with pudding thick liquids, carnation instant breakfast [sic] with 8 ounces whole milk, as a snack on the PM shift. Extra 8 ounces fluid 4 X daily. Inner lip plate with adaptive spoon. [Individual #1] - Regular diet cut into bite size pieces, large portions with seconds or thirds on food likes, carnation instant breakfast [sic] with 9 ounces whole milk 3 X daily with meals, [sic] Food snack with increased calories at 10 am and 7 pm daily. High sided plate with a large spoon. [Individual #3] - Regular diet cut into bite size pieces, 8 ounces whole milk with carnation instant breakfast [sic] with breakfast. & [sic] one with Dinner [sic]. Cut out plate with weighted spoon, glass. Please use straw. [Individual #5] - Regular pureed diet thickened to	W 112		

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W 112	Continued From page 2 pudding thick, pudding thick liquids, carnation Instant breakfast [sic] with 8 ounces whole milk 3 times daily PRN for less than 75% or less a CIB (Carnation Instant breakfast) needs to be given thru G-tube (gastric feeding tube). The CIB to be given every day. Divided plate with spoon." Additionally, a document titled "Hand Splint usage [sic]" was posted on a kitchen cabinet door. The document included Individual #5's first name and initial of his last name at the top. The schedule stated he was to wear the splints on his right and left hand from 8:00 to 10:00 p.m. When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the Administrator stated the documents should not have been posted in a common area that was available to everyone and should have been removed. The facility failed to ensure information regarding individuals' nutritional and adaptive equipment needs was kept confidential.	W 112		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination for 6 of 6 individuals (Individuals #1 - #6) residing in facility. That failure resulted in individuals not receiving the services and training required to meet their needs. The findings	W 159	**W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL** In order to ensure that the QMRP provides sufficient monitoring and coordination of the status of the Cornerstone clients, the plan of correction for the following federal listed under W 159 will serve as the plan of action to ensure Individuals residing at Cornerstone will receive services and required training to meet their development and behavioral needs.	

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W 159	Continued From page 3 include: 1. Refer to W112 as it relates to the QMRP's failure to ensure individuals' nutritional and adaptive equipment needs were kept confidential. 2. Refer to W168 as it relates to the QMRP's failure to ensure professional staff adequately participated as members of the IDT, as individual needs indicated. 3. Refer to W214 as it relates to the QMRP's failure to ensure the individuals' behavior assessments included comprehensive information on which to base program decisions. 4. Refer to W218 as it relates to the QMRP's failure to ensure individuals' functional assessments included specific information. 5. Refer to W239 as it relates to the QMRP's failure to ensure appropriate replacement behaviors were identified and incorporated into the individuals' behavior management plans. 6. Refer to W253 as it relates to the QMRP's failure to ensure the individuals' significant events were documented. 7. Refer to W262 as it relates to the QMRP's failure to ensure restrictive interventions were implemented only with human rights committee approval. 8. Refer to W263 as it relates to the QMRP's failure to ensure restrictive interventions were implemented only with the approval of the individuals' parent/guardian.	W 159	Please refer to W112, W168, W214, W218, W239, W253, W262, W263, W278, W322, W331, and W489 for specific information relating to those deficiencies. To be completed by the QMRP, Behavioral Specialist, and Administrator by 10/27/08.	

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W 159	Continued From page 4 9. Refer to W278 as it relates to the QMRP's failure to ensure the individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage maladaptive behavior. 10. Refer to W322 as it relates to the QMRP's failure to ensure general and preventative health care was provided to individuals. 11. Refer to W331 as it relates to the QMRP's failure to ensure individuals' were provided with nursing services in accordance with their needs. 12. Refer to W489 as it relates to the QMRP's failure to ensure individuals were positioned appropriately while dining.	W 159		
W 168	483.430(b)(3) PROFESSIONAL PROGRAM SERVICES Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure professional staff adequately participated as members of the IDT, as individual needs indicated, for 1 of 3 individuals (Individual #1) whose records were reviewed. This resulted in a lack of IDT input related to dietary needs for individual #1. The findings include: Individual #1's IPP, dated 4/02/08, documented a 33 year old male whose diagnoses included profound mental retardation and spastic	W 168	**W 168 483.430(b)(3) PROFESSIONAL PROGRAM SERVICES** Professional program staff will participate as members of the IDT in aspects of the active treatment process. The dietician will be involved in the IPP's and will be consulted on a weight loss greater than 5lbs. The RN will also monitor weigh loss greater then 5lbs. The RN will also be involved in the IPP process. The dietician will be involved with all mealtime programming of all Cornerstone clients. The dietician will assess all dietary concerns on a quarterly basis. The monthly weights will be addressed by the RN and noted in chart notes, to ensure the deficient does not recur.	

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W 168	Continued From page 5 quadriparesis. Individual #1's record included an objective which stated: "[Individual #1] will eat his meal without yelling, laughing loudly, and/or banging his spoon 95% of trials for six consecutive months." The program instructions stated "If [Individual #1] yells, laughs loudly and/or bangs his spoon during the meal, staff say [sic], '[Individual #1], when you _____, you have to wait to eat' and staff pull [sic] [Individual #1] back from the table for 5 minutes. After 5 minutes, move [Individual #1] back to the table to eat. Repeat each time [Individual #1] yells, laughs loudly, and/or bangs his spoon." Individual #1's record also included an objective which stated: "When asked '[Individual #1] would you like more _____?' [Individual #1] will independently answer 'yes'/'no' 75% of the trails for six consecutive months." The "STATUS" section of the objective stated "[Individual #1] inconsistently uses the words 'yes' and 'no' in response to questions. When [Individual #1] says 'yes' he usually means, [sic] 'yes'. However, when he says 'no', [sic] he sometimes means 'yes' [sic], and he has a tendency to say 'no' in response to any questioning intonation." The program instructions stated that "If [Individual #1] refuses to answer staff says [sic] '[Individual #1], if you don't answer I will take that as a 'no'. Staff [sic] does not give him anymore food." Individual #1's record included an undated "Nutritional Assessment" which included monthly weights for Individual #1 from January 2007 through February of 2008. His weight for 2/08 was listed as 110 pounds and his IBWR (Ideal Body Weight Range) was given as 139 - 169	W 168	To be completed by the LPN, RN, Dietician, and Administrator by 10/27/08.	

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W 168	Continued From page 6 pounds. This assessment also stated Individual #1's current diet order was a regular diet with high calorie snacks. A physician's exam form, dated 6/19/08, documented that Individual #1's weight was 107 pounds and had decreased by 3 pounds. Individual #1's weight was 32 pounds below his minimum ideal body weight. When asked if the Dietitian was aware of the mealtime programs related to Individual #1's dietary intake, during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the QMRP stated he had not discussed the programs with the whole team and that the Dietitian was not aware of Individual #1's programs. The facility failed to ensure Individual #1's IDT was given the opportunity to provide input regarding Individual #1's dietary needs and mealtime programs.	W 168		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 2 of 3 individuals (Individuals #1 and #2) whose behavioral assessment were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's IPP, dated 4/02/08, documented a 33 year old male whose diagnoses included	W 214	**W 214 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN** Behavioral assessments for all 6 clients residing at Cornerstone will be completed or re-assessed. The behavioral assessments and the IPP's, along with the SIB-R's will be cross referenced to ensure that no pertinent information is missed, and that all comprehensive information is included. Then that information will be included in all 6 clients IPP. This will be done every time that there is a revision made to an assessment and yearly at the IPP meeting to ensure this deficient will not recur.	

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W 214	Continued From page 7 profound mental retardation and spastic quadriparesis. Individual #1's record included an objective which stated: "[Individual #1] will eat his meal without yelling, laughing loudly, and/or banging his spoon 95% of trials for six consecutive months." The program instructions stated "If [Individual #1] yells, laughs loudly and/or bangs his spoon during the meal, staff say [sic], '[Individual #1], when you _____, you have to wait to eat' and staff pull [sic] [Individual #1] back from the table for 5 minutes. After 5 minutes, move [Individual #1] back to the table to eat. Repeat each time [Individual #1] yells, laughs loudly, and/or bangs his spoon." However, Individual #1's behavior assessment, dated 4/3/08, stated the following: "Strengths: [Individual #1] is generally content in his environment. [Individual #1] rarely engages in inappropriate behavior. [Individual #1] is able to use some words to communicate. [Individual #1] is able to answer some Yes/No questions. [Individual #1] is able to request and protest using words and gestures [sic] [Individual #1] has independent eating skills [sic] Needs: No formal interventions needed at this time." When asked about the behavior assessment, during an interview on 7/31/08 from 10:40 a.m. -12:30 p.m., the QMRP stated no additional	W 214	Quarterly checks will be conducted, monitoring will be done to make sure the IPP's, behavioral assessments, all match with no missing information. This will be done by the QMRP, Behavioral Specialist, and the Administrator by 10/27/08.	

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W 214	Continued From page 8 information related to Individual #1's eating his meal without yelling, laughing loudly, and/or banging his spoon was contained in his behavioral assessment. Additionally, Individual #1's record included a Written Informed Consent, dated 4/4/08, that stated he received Valium (an anxiolytic drug) 15 mg. and physical restraint (holding Individual #1's hands as needed) for dental procedures because he "becomes combative - hitting, kicking, and yelling." No information related to Individual #1's restraint usage, dental procedure, or hitting, kicking, and yelling during dental exams was found in his behavior assessment. When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the QMRP stated Valium and restraint usage related to Individual #1's dental procedure had not been assessed. The facility failed to ensure Individual #1's functional assessment included comprehensive, consistent information related to his behavioral management needs. 2. Individual #2's 2/4/08 IPP stated he was a 38 year old male whose diagnoses included quadriplegia, kyphoscoliosis, and profound mental retardation. His IPP included a section titled "Maladaptive Behaviors" which stated "[Individual #2] screams and cries to avoid things he does not like, he rocks his chair, and masturbates at inappropriate times." No additional information regarding the behaviors was found in his IPP. Individual #2's SIB-R (Scales of Independent Behavior-Revised), dated 6/14/06, listed the	W 214		

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W 214	Continued From page 9 following maladaptive behaviors: - Screaming one to ten times a day. - Masturbation one to six time a week. - Non-compliance one to ten times a day. No additional information regarding the behaviors was found in his SIB-R. Individual #2's Behavioral Assessment, dated 2/16/08, included two sections, one titled "Strengths" and one titled "Needs." The "Strengths" section stated "[Individual #2] is generally content in his environment. [Individual #2] rarely engages in inappropriate behavior." The "Needs" section stated "No formal interventions needed at this time." Individual #2's Behavioral Assessment contained no additional information (i.e., those behaviors assumed to be maladaptive as identified in the IPP and SIB-R, an analyses of the potential causes of those behaviors such as lack of exposure to positive models and teaching strategies, lack of ability to communicate needs and desires, lack of success experiences, a history of punishing experiences, or other environmental or social conditions which may elicit or sustain the behaviors). When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the QMRP stated there was no additional information assessing Individual #2's maladaptive behavior. The facility failed to ensure Individual #2's behavior assessment contained sufficient and comprehensive information.	W 214		
W 218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN	W 218		

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	13G056	A. BUILDING _____ B. WING _____	07/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 218	Continued From page 10 The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure the comprehensive functional assessment included comprehensive sensorimotor development information for 1 of 4 individuals (Individual #4) whose functional assessments were reviewed. This resulted in the use of a mechanical support for an individual without clear direction regarding its use. The findings include: 1. Individual #4 was a 33 year old female whose diagnoses included profound mental retardation. She was non-ambulatory and required a wheel chair for mobility. Individual #4 had a program to use a CSO (Crutchless Standing Orthosis - a mechanical device which held the individual in a standing position) for supported weight bearing. The program objective stated she would stand in the CSO for 30 minutes twice daily. The plan included the following instructions for staff: "1. [Individual #4] is to have on high topped shoes. 2. Position in CSO 3. Ensure hip, knee, and waist supports are in place 4. Ensure the heal support bar is in proper position 5. Encourage [Individual #4] to stand while he [sic] is in the stander 6. Record in comments section of data sheet length of time standing and any other relevant comments."	W 218	**W 218 483.440(c)(3)(v)** **INDIVIDUAL PROGRAM PLAN** Individual #4 will receive a PT eval to assess the use of the CSO, the functional assessment will be re-assessed to include all pertinent information involving the CSO. All information will be specific. All clients using the CSO will have specific information in the functional assessment and the PT evaluation, to ensure the deficient will not recur. The maintenance man for Wendell will replace/repair the broken latch on the CSO. To be monitored monthly by the QMRP, and Administrator To be completed by 10/27/08	

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W 218	Continued From page 11 During an observation on 7/29/08 from 3:20 - 4:18 p.m., Individual #4 was noted to be positioned in the CSO. Individual #4 was observed to be wearing regular tennis shoes. Additionally, the back gate of the CSO was noted to be opened. The staff working with Individual #4 was asked about the gate during the observation and stated the gate should be closed and latched, but the latch was broken. The QMRP, who was present during the observation, was asked about Individual #4's program for the CSO and stated he had written the program. Individual #4's Physical Therapy Examination, dated 2/20/06, stated "Per caregiver report, [Individual #4] stands in the standing table [e.g., COS] daily for 30 minutes." Under the "Recommendations" section the examination stated "Continued [sic] daily standing table time for 30 minutes." No additional information regarding the CSO or its use was found in the assessment. When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the Administrator stated Individual #4 never had high topped shoes. The QMRP, who was present during the interview, stated Individual #4's program for the use of the CSO did not match the assessment regarding time, and stated the physical therapist had not provided assessment for how the CSO should be used. The facility failed to ensure Individual #4's functional assessment contained specific information regarding the use of the CSO.	W 218		

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W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior management plan for 1 of 3 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted an individual not receiving training to replace his maladaptive mealtime behavior. The findings include: 1. Individual #1's IPP, dated 4/021/08, documented a 33 year old male whose diagnoses included profound mental retardation and spastic quadriparesis. Individual #1's record included an objective which stated: "[Individual #1] will eat his meal without yelling, laughing loudly, and/or banging his spoon 95% of trials for six consecutive months." The program instructions stated "If [Individual #1] yells, laughs loudly and/or bangs his spoon during the meal, staff say [sic], '[Individual #1], when you _____, you have to wait to eat' and staff pull [sic] [Individual #1] back from the table for 5 minutes. After 5 minutes, move [Individual #1] back to the table to eat. Repeat each time [Individual #1] yells, laughs loudly, and/or bangs his spoon."	W 239	**W 239 483.440(C)(5)(VI) INDIVIDUAL PROGRAM PLAN** Each written training program designed to implement the objectives in the IPP will specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior. Client #1 will be re-assessed for his behavior's at mealtime if appropriate. if appropriate then a replacement behavior will be trained and implemented. all 6 clients will be assessed for inappropriate behavior's and if needed replacement behavior's will be implemented, to ensure the deficient will not recur. To be monitored monthly by the RSC, and the Administrator. To be completed by the QMRP, RSC and the Administrator by 10/27/08.	

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W 239	Continued From page 13 Individual #1's record did not include information related to training he was receiving to appropriately replace his maladaptive mealtime behavior. When asked, during an interview on 7/31/08 from 10:40 a.m. - 12: 30 p.m., about training to appropriately replace Individual #1's maladaptive mealtime behavior, the QMRP stated Individual #1 was not receiving such training. The facility failed to ensure a Individual #1 received training to appropriately replace his maladaptive mealtime behavior.	W 239		
W 253	483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure significant events were documented for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in a lack of sufficient documentation related to individuals' medical and dining needs. The findings include: 1. Individual #3's 4/14/08 IPP stated he was a 17 year old male. His diagnoses included moderate mental retardation and cerebral palsy. During an observation on 7/28/08 from 5:15 - 6:10 p.m., Individual #3 was noted to be in the kitchen with staff. Staff asked Individual #3 if he was "vomiting" again. Staff wiped a small amount of	W 253	**W 253 483.440(e)(2) PROGRAM DOCUMENTATION** The facility will document significant events that are related to the client's individual program plan and assessments. complete documentation will be recorded on client #3 rumination so the facility can adequately monitor his current status and identify significant changes to his health condition. Health assessments will be done on any 6 clients that reside at Cornerstone that is deemed appropriate and needed. Health concerns will be monitored monthly by the RN upon chart review. Documentation if needed will be charted and reviewed monthly, to ensure the deficient will not recur.	

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W 253	Continued From page 14 emesis from Individual #3's shirt with a damp cloth. Individual #3 was noted to bring food up into his mouth and re-swallow it no less than 8 times. Individual #3's 11/25/07 Annual Nursing Summary stated "On 2-22-07, [Individual #3] was admitted to [hospital name] for biopsies of stomach, esophagus, and duodenum by [name of physician]. The findings were as follows: esophageal tissue showed chronic inflammation, gastric tissue showed inflammation and h-pylori negative, nothing found on duodenal tissue. On 3-15-07, [Nurse Practitioner] was here for rounds. [Individual #3] continues to have rumination (an eating disorder in which the sufferer brings up partially digested food and re-chews it before swallowing it or spitting it out) with chewing and re-swallowing." Individual #3's Nurse's Notes documented the following: - 8/8/07: "Rumination (continue with) plans to (follow up with) surgeon." - 8/27/07: A late entry for 8/24/07 stated "This nurse asked how many times res (resident) is regurging [sic]. They stated one time (after) brkft (breakfast) between then (and) time to load on bus." - 8/27/07: "This nurse asked again how many times res regurged [sic] over wknd (weekend). Staff stated 2 times." - 9/17/07: "Staff c/o (complain of) approx (approximately) 2X wkly (times weekly) of regurgitation. - 9/28/07: "Res continues on Reglan (a gastrointestinal tract drug) for Rumination (related to) slow gastric Emptying [sic] doing progressively (with) about 20 times per day compared to some	W 253	To be completed by the RN, and LPN by 10/27/08.	

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W 253	Continued From page 15 300 times per day." - 2/14/08: "Rumenation [sic] (without change)." - 3/31/08: a late entry for 3/27/08 stated "chronic rumination (without change)." - 4/17/08: "chronic rumination (without change)." - 5/28/08: A late entry for 5/15/08 stated "Chronic rumination (without change)." - 6/9/08: "Res to [Nurse Practitioner] for (follow-up) on regurge [sic]. [Nurse Practicer] said to continue Reglan (for one week) if S+S (signs and symptoms) improve (continue with) reglan [sic] if S+S persist stop reglan [sic] (and) start Emycin [sic] (an anti-infective drug) 250 TID (three times daily)..." - 6/16/08: "Res regurg [sic] (with) actual vomiting has (decreased). Will (continue with) Reglan..." - 6/19/08: "chronic rumination stable" - 7/9/08: "Res continue to have emesis (with) rumination after meals. Started Erythromycin (an anti-infective drug) 250 mg 1 tab (tablet) TID 20 minutes before each meal. also [sic] started yogurt 3X wkly M-W-F (3 times weekly, Monday, Wednesday, and Friday) for 10 Am [sic] snack as directed by [Nurse Practitioner]." - 7/14/08: "Staff c/o over wknd that res is vomitting [sic] (after) meals (and after) being layed [sic]down in afternoon. res [sic] continues (with) rumination (after) meals between meals [sic]." - 7/21/08: "Res continues to ruminate (with) emesis at least 2 times wkly." When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the LPN stated rumination was not defined but was very obvious. The LPN stated Individual #3's rumination was not documented unless it resulted in emesis. The LPN also stated if Individual #3 ruminated into his mouth and re-swallowed, the incident was not	W 253		

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W 253	Continued From page 16 documented. Without complete documentation related to the frequency of Individual #3's rumination, it would not be possible for the facility adequately monitor his current status and identify significant changes to his health condition. The facility failed to ensure the documentation of significant events related to Individual #3 health condition.	W 253		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 2 of 3 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals on restrictive interventions. The findings include: 1. Individual #1's IPP, dated 4/021/08, documented a 33 year old male whose diagnoses included profound mental retardation and spastic quadriparesis. Individual #1's record included an objective which stated: "[Individual #1] will eat his meal without	W 262	**W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE** All Cornerstone clients on Restrictive programs, will have all components added to their consents. All restrictive programs will be taken before the parents, legal guardians, and the HRC committee. this will happen before the restriction occurs. All Cornerstone clients will be reviewed, quarterly by the HRC to ensure that the deficient will not recur. To be completed by the QMRP, and Administrator by 10/27/08.	

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W 262	Continued From page 17 yelling, laughing loudly, and/or banging his spoon 95% of trials for six consecutive months." The program instructions for this objective stated that "If [Individual #1] yells, laughs loudly and/or bangs his spoon during the meal, staff say [sic], '[Individual #1], when you _____, you have to wait to eat' and staff pull [sic] [Individual #1] back from the table for 5 minutes. After 5 minutes, move [Individual #1] back to the table to eat. Repeat each time [Individual #1] yells, laughs loudly, and/or bangs his spoon." However, Individual #1's record did not contain evidence of HRC approval for the restrictive intervention. When asked, the QMRP stated during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., that the program was restrictive, but that HRC approval had not been obtained. The facility failed to ensure HRC approval was obtained prior to the use of restrictive interventions. 2. Individual #2's 2/4/08 IPP stated he was a 38 year old male whose diagnoses included quadriplegia, kyphoscoliosis, and profound mental retardation. Individual #2's dental notes, dated 4/21/08, stated he received Valium (an anxiolytic drug) 20 mg two hours prior to his dental appointment. Individual #2's consent for the use of Valium prior to dental appointments, dated 2/4/08, was not signed by the HRC until 6/12/08. The record contained no additional information regarding HRC approval for the use of Valium prior to dental appointments.	W 262		

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W 262	Continued From page 18 When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the QMRP stated HRC telephone approval had probably been obtained but not documented. The facility failed to ensure Individual #2's pre-medication for dental appointments was approved by the HRC.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 2 of 3 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approval of a restrictive intervention. The findings include: 1. Individual #1's IPP, dated 4/02/08, documented a 33 year old male whose diagnoses included profound mental retardation and spastic quadriparesis. Individual #1's record included an objective which stated: "[Individual #1] will eat his meal without yelling, laughing loudly, and/or banging his spoon 95% of trials for six consecutive months." The program instructions stated "If [Individual #1] yells, laughs loudly and/or bangs his spoon during	W 263	**W 263 483.440(f)(3)(ii) PROGRAM MONITORING AND CHANGE.** All clients that have restrictive components to them, will have prior consent given by HRC, parents, and/or legal guardians. Restrictive programs will be reviewed by a checklist monitoring the Q books quarterly, to ensure this deficient will not recur. To be completed by the QMRP, Behavioral Specialist, and Administrator. By 10/27/08.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 263	Continued From page 19 the meal, staff say [sic], '[Individual #1], when you _____, you have to wait to eat' and staff pull [sic] [Individual #1] back from the table for 5 minutes. After 5 minutes, move [Individual #1] back to the table to eat. Repeat each time [Individual #1] yells, laughs loudly, and/or bangs his spoon." However, Individual #1's record did not contain evidence of approval of the parent/guardian for the restrictive intervention. When asked, the QMRP stated during an interview on 7/31/08 from 10:40 a.m. -12:30 p.m., that the program was restrictive, but that approval of the parent/guardian had not been obtained. The facility failed to ensure approval of the parent/guardian approval was obtained prior to the use of restrictive interventions. 2. Individual #2's 2/4/08 IPP stated he was a 38 year old male whose diagnoses included quadriplegia, kyphoscoliosis, and profound mental retardation. Individual #2's dental notes, dated 4/21/08, stated he received Valium (an anxiolytic drug) 20 mg two hours prior to his dental appointment. Individual #2's consent for the use of Valium prior to dental appointments, dated 2/4/08, was not signed by the his guardian until 6/10/08. The record contained no additional information regarding guardian consent for the use of Valium prior to dental appointments. When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the QMRP stated guardian telephone consent had probably been	W 263		

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W 263	Continued From page 20 obtained but not documented. The facility failed to ensure Individual #2's pre-medication for dental appointments was not used until guardian consent had been obtained.	W 263		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior. This failure directly impacted 1 of 1 individuals (Individual #1) who had restrictive dining interventions and had the potential to impact the other 5 individuals (Individuals #2 - #6) residing in the facility. This resulted in interventions being used without the necessary facility approvals. Findings include: 1. Individual #1's IPP, dated 4/02/08, documented a 33 year old male whose diagnoses included profound mental retardation and spastic quadriparesis. Individual #1's record included an objective which stated: "[Individual #1] will eat his meal without yelling, laughing loudly, and/or banging his spoon 95% of trials for six consecutive months." The program instructions stated "If [Individual #1] yells, laughs loudly and/or bangs his spoon during the meal, staff say [sic], '[Individual #1], when you _____, you have to wait to eat' and staff pull	W 276	**W 276 483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR.** The facility will not practice the intervention of delaying individuals meals, the behavior policy for Preferred Community Homes will be followed as written. This will be monitored quarterly with the program status checklist. To be completed by the QMRP, Behavioral Specialist, and Administrator, By 10/27/08.	

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W 276	Continued From page 21 [sic] [Individual #1] back from the table for 5 minutes. After 5 minutes, move [Individual #1] back to the table to eat. Repeat each time [Individual #1] yells, laughs loudly, and/or bangs his spoon." The facility's "Behavioral Method Hierarchy and Definitions" policy, revised 7/27/07, included a list a behavioral interventions in a hierarchy of levels (level 1 - 6) from least restrictive to most restrictive. The policy did not include the intervention of delaying individuals' meals. When asked during an interview on 7/31/08 from 10:40 a.m. -12:30 p.m., the QMRP stated delaying an individual's meals had not been incorporated into the behavior policy or hierarchy. The facility failed to ensure the behavior policy included all interventions used to manage the individuals' maladaptive behaviors.	W 276		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive	W 278	**W 278 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR.** When evidence of less restrictive alternatives have been tried and proven ineffective, and prior to the implementation of the start of a restrictive program, all evidence will be documented, and recorded in the QMRP book. quarterly monitoring will be done for all clients residing at Cornerstone to ensure this deficient will not recur.	

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W 278	Continued From page 22 techniques to manage behavior for 1 of 3 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in the potential for individuals to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #1's IPP, dated 4/02/08, documented a 33 year old male whose diagnoses included profound mental retardation and spastic quadriparesis. Individual #1's record included an objective which stated: "[Individual #1] will eat his meal without yelling, laughing loudly, and/or banging his spoon 95% of trials for six consecutive months." The program instructions stated "If [Individual #1] yells, laughs loudly and/or bangs his spoon during the meal, staff say [sic], '[Individual #1], when you _____, you have to wait to eat' and staff pull [sic] [Individual #1] back from the table for 5 minutes. After 5 minutes, move [Individual #1] back to the table to eat. Repeat each time [Individual #1] yells, laughs loudly, and/or bangs his spoon." When asked for evidence of less restrictive alternatives that were systematically tried and proven ineffective prior to the implementation of the restrictive program, the QMRP stated during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., he thought other things were tried but stated they were not documented. No evidence or documentation of more positive or less restrictive programs having been attempted was found or provided to the survey team. The facility failed to ensure there was sufficient evidence of less restrictive alternatives that were	W 278	To be completed by the QMRP, Behavioral Specialist, and Administrator by 10/27/08.	

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W 278	Continued From page 23 systematically tried and proven ineffective prior to implementing the restrictive dining program for Individual #1.	W 278		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure general care was provided to 4 of 4 individuals (Individuals #2, #3, #5, and #6) whose medical records were reviewed. This failure resulted in a lack of sufficient information being provided to medical personnel. The findings include: 1. Individual #3's 4/14/08 IPP stated he was a 17 year old male. His diagnoses included moderate mental retardation and cerebral palsy. During an observation on 7/28/08 from 5:15 - 6:10 p.m., Individual #3 was noted to be in the kitchen with staff. Staff asked Individual #3 if he was "vomiting" again. Staff wiped a small amount of emesis from Individual #3's shirt with a damp cloth. Individual #3 was noted to bring food up into his mouth and re-swallow it no less than 8 times. Individual #3's 11/25/07 Annual Nursing Summary stated "On 2-22-07, [Individual #3] was admitted to [hospital name] for biopsies of stomach, esophagus, and duodenum by [name of physician]. The findings were as follows: esophageal tissue showed chronic inflammation, gastric tissue showed inflammation and h-pylori	W 322	**W 322 483.460(a)(3)** **PHYSICIAN SERVICES** The facility will provide preventive and general medical care for all clients living at Cornerstone. Individual #3 will have complete documentation of his rumination and emesis, so the Dr. can adequately assess and make recommendations regarding possible interventions. Individual #5 will have complete documentation of all of his meals to ensure that he receives adequate nutritional intake, this will be monitored weekly by checking the food intake sheet. Individual #2 will have an Ophthalmology appointment to get a clear diagnosis of his eye site. Individual #6 missed follow up on a request from the pharmacy, will be monitored monthly and documented on monthly RN chart notes. All clients Physician and Nursing Services will be reviewed monthly to ensure the deficient will not recur. To be completed by the RN, LPN, And the Administrator by 10/27/08.	

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W 322	Continued From page 24 negative, nothing found on duodenal tissue. On 3-15-07, [Nurse Practitioner] was here for rounds. [Individual #3] continues to have rumination (an eating disorder in which the sufferer brings up partially digested food and re-chews it before swallowing it or spitting it out) with chewing and re-swallowing." Individual #3's Nurse's Notes documented the following: - 8/8/07: "Rumination (continue with) plans to (follow up with) surgeon." - 8/27/07: A late entry for 8/24/07 stated "This nurse asked how many times res (resident) is regurging [sic]. They stated one time (after) brkft (breakfast) between then (and) time to load on bus." - 8/27/07: "This nurse asked again how many times res regurged [sic] over wknd (weekend). Staff stated 2 times." - 9/17/07: "Staff c/o (complain of) approx (approximately) 2X wkly (times weekly) of regurgitation. - 9/28/07: "Res continues on Reglan (a gastrointestinal tract drug) for Rumination (related to) slow gastric Emptying [sic] doing progressively (with) about 20 times per day compared to some 300 times per day." - 2/14/08: "Rumenation [sic] (without change)." - 3/31/08: a late entry for 3/27/08 stated "chronic rumination (without change)." - 4/17/08: "chronic rumination (without change)." - 5/28/08: A late entry for 5/15/08 stated "Chronic rumination (without change)." - 6/9/08: "Res to [Nurse Practitioner] for (follow-up) on regurge [sic]. [Nurse Practicer] said to continue Reglan (for one week) if S+S (signs and symptoms) improve (continue with) reglan [sic] if S+S persist stop reglan [sic] (and)	W 322		

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W 322	Continued From page 25 start Emycin [sic] (an anti-infective drug) 250 TID (three times daily)..." - 6/16/08: "Res regurg [sic] (with) actual vomiting [sic] has (decreased). Will (continue with) Reglan..." - 6/19/08: "chronic rumination stable" - 7/9/08: "Res continue to have emesis (with) rumination after meals. Started Erythromycin (an anti-infective drug) 250 mg 1 tab (tablet) TID 20 minutes before each meal. also [sic] started yogurt 3X wkly M-W-F (3 times weekly, Monday, Wednesday, and Friday) for 10 Am [sic] snack as directed by [Nurse Practitioner]." - 7/14/08: "Staff c/o over wknd that res is vomitting (after) meals (and after) being layed [sic] down in afternoon. res [sic] continues (with) rumination (after) meals between meals [sic]." - 7/21/08: "Res continues to ruminate (with) emesis at least 2 times wkly." When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the LPN stated rumination was not defined but was very obvious. The LPN stated individual #3's rumination was not documented unless it resulted in emesis. If Individual #3 ruminated into his mouth and re-swallowed, the incident was not documented. Without complete documentation related to the frequency of Individual #3's rumination, it would not be possible for the physician to adequately assess or make recommendations regarding possible intervention strategies. The facility failed to ensure adequate information was collected and communicated to Individual #3's physician. 2. Individual #5's 8/2/07 Nutritional Assessment stated he was a 16 year old male whose diagnoses included mental retardation, seizure	W 322		

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W 322	Continued From page 26 disorder, and spastic quadriparesis. He required a wheelchair for mobility. The Nutritional assessment stated his swallowing ability was impaired and that he required full assistance with meals. All foods were pureed and liquids were thickened to pudding thickness. Individual #5's Tube Feeding Record, dated July 2008, stated he was to receive CIB (Carnation Instant Breakfast) with 8 ounces of whole milk PRN after breakfast, lunch, and dinner if less than 75 percent of his meal was eaten. During an observation on 7/28/08 from 5:15 - 6:10 p.m., Individual #5 was noted to be positioned in his wheelchair next to the dinning table. A staff member was standing beside Individual #5 holding a divided plate that contained pureed food. The staff reported she was feeding Individual #5 carrot and raisin salad, and that the divided plate also contained chicken casserole and cake. Additionally, staff fed Individual #5 cherry KoolAid that had been thickened. Upon completion of the meal, Individual #5 had eaten less than 25 percent of the meal. On 7/29/08, Individual #5's Food Intake Sheet was reviewed. The space marked "Dinner" for 7/28/08 was blank. Additionally, the spaces for 10:00 a.m. snack, lunch, 3:00 p.m. snack and 7:00 p.m. snack on 7/27/08 were blank. The spaces for 10:00 a.m. snack, 3:00 p.m. snack, and 7:00 p.m. snack were also blank on 7/28/08. Without complete documentation the facility would not be able to ensure Individual #5 received adequate daily nutritional intake. When asked during an interview on 7/31/08 from	W 322		

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W 322	Continued From page 27 10:40 a.m. - 12:30 p.m., the LPN stated staff should document Individual #5's meals on the Food Intake Sheet. The facility failed to ensure Individual #5's nutritional intake was sufficiently documented. 3. Refer to W331 as it relates to the facility's failure to ensure individuals' were provided with nursing services in accordance with their needs.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure nursing services were provided as needed for 2 of 4 individuals (Individuals #2 and #6) whose medical records were reviewed. This resulted in individuals' not receiving adequate follow up related to diagnoses and lab results. Findings include: 1. Individual #2's 2/4/08 IPP stated he was a 38 year old male whose diagnoses included quadriplegia, kyphoscoliosis, and profound mental retardation. Under the "Receptive Language" section of his IPP was documented "[Individual #2] visually attends to items he prefers, even though he has been diagnosed with cortical blindness." Individual #2's Ophthalmology report, dated 6/19/06, stated Individual #2 "has myopia in both eyes with exotropia in the left eye. No treatment is recommended at this time." The report did not	W 331	**W 331 483.460(c) NURSING SERVICES** Refer to W322	

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W 331	Continued From page 28 include documentation of a diagnosis of cortical blindness. Individual #2's Annual Evaluation from the Nurse Practitioner, dated 2/28/08, included a diagnosis of cortical blindness. This diagnosis was also included in Individual #2's 5/15/08 Speech Language Evaluation, which stated progress with program may be inhibited due to cortical blindness. Without clear diagnoses for visual impairments that may effect communication programs, the Speech and Language Pathologist would not be able to make appropriate program recommendations. When asked during an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the LPN stated she was not sure how the diagnosis of cortical blindness had been determined and did not believe it was accurate. The LPN stated Individual #2 had been to the Ophthalmologist a "couple of weeks ago" but she had not obtained the report and was not aware of the current diagnosis. The facility failed to ensure the LPN followed through with clarification of Individual #2's visual diagnosis. 2. Individual #6 was a 34 year old male whose diagnoses included profound mental retardation. Individual #6's medical record was reviewed on 7/30/08. A neurological exam could not be found. Individual #6's record contained a pharmacy review form that included the following information:	W 331		

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W 331	Continued From page 29 - 1/3/08: "Please include Theophylline level in next Blood Lab Work." The LPN noted the request on 1/4/08. - 4/24/08: "Theophylline test was done on 1/14/08. Please get the copy from Lab." The LPN noted the request on 4/28/08. - 6/28/08: "Please get copy of Theophylline Level." The entry was not noted. Individual #6's record did not include the requested lab work. During an interview on 7/31/08 from 10:40 a.m. - 12:30 p.m., the LPN stated Individual #6 had been to the neurologist sometime in the past year but the report had not been obtained. The LPN stated Individual #6's lab work had been completed but the report had not been obtained. When asked why follow through with obtaining the reports had not occurred, the LPN stated it was due to an over-site. On 7/31/08, the LPN requested and received copies of Individual #6's 8/9/07 neurological follow up and 1/14/08 lab results. The facility failed to ensure the LPN obtained needed documentation and followed up on pharmacy review requests for Individual #6.	W 331		
W 489	483.480(d)(5) DINING AREAS AND SERVICE The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observation, record review, and	W 489	**W 489 483.480(d)(5) DINING AREAS AND SERVICE** The facility will ensure that clients eat at the appropriate positions. Individual #5 will have a OT consult as to the appropriate position. #5 will also have a dietary consult as to the appropriate position.	

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W 489	Continued From page 30 interview, it was determined the facility failed to ensure individuals were positioned appropriately while dining for 1 of 6 individuals (Individual #5) who were observed eating. This resulted in an increased potential for an individual to experience swallowing difficulties and choking. The findings include: 1. Individual #5's 8/2/07 Nutritional Assessment stated he was a 16 year old male whose diagnoses included mental retardation, seizure disorder, and spastic quadriparesis. He required a wheelchair for mobility. The Nutritional assessment stated his swallowing ability was impaired and that he required full assistance with meals. All foods were pureed and liquids were thickened to pudding thickness. During an observation on 7/28/08 from 5:15 - 6:10 p.m., Individual #5 was noted to be positioned in his wheelchair next to the dinning table. Individual #5's wheelchair was at a 45 degree angle. A staff member was standing beside Individual #5 holding a divided plate that contained pureed food. The staff reported she was feeding Individual #5 carrot and raisin salad. Using a regular spoon, staff would scoop pureed food onto the spoon and place the food in Individual #5's mouth. From 5:20 - 5:30 p.m., Individual #5 was noted to cough when food was placed in his mouth no less than 6 times. Staff would hold a washcloth over Individual #5's mouth until he finished coughing, would wipe his mouth, and would continue to spoon food into his mouth. When asked about the angle of his chair, during an interview on 7/29/08 at 4:10 p.m., the staff	W 489	The IDT will meet to ensure that client #5 will eat in the appropriate position. This will be monitored monthly thru observations and documented in observation notes. To be completed by the RSC, and the Administrator by 10/27/08.	

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W 489	Continued From page 31 observed feeding Individual #5 stated the wheelchair is reclined to prevent Individual #5 from spitting up his food. The staff stated Individual #5's program did not indicate he should be in a reclined position, and she was not sure how far back his wheelchair should be positioned. Individual #5's Occupational Therapy Evaluation, dated 1/14/08, stated "[Individual #5] is a coughing and choking risk at mealtime. He is positioned in his wheel chair with a slight reline [sic] position (10-20 degrees) and neck and headrest in place to provide adequate neck and head support." Additionally, Individual #5's Nurse's Notes, dated 4/17/08, stated "cont. (continue) pureed diet feed upright [sic]." When asked during an interview with the Administrator, QMRP, LPN, and Lead Worker, on 7/31/08 from 10:40 a.m. - 12:30 p.m., the Administrator stated Individual #5's wheelchair should be reclined to a 10 - 20 degree angle as per the Occupational Therapy report. The LPN stated Individual #5's wheelchair should be in a 45 degree angle when being fed via his G-tube, but not while being fed by mouth. The facility failed to ensure Individual #5 ate in an upright position.	W 489		

09/03/08

Keep @ POC.

Addendum to Cornerstone Survey, Provider #13G056

W 168----Client #1 Program has been removed.

W 262---Client #1 Program has been removed. Client #2 Consent 's were re-done.

W 263—Please refer to W 262.

W 278—Client #1 Program has been removed.

W 489—Observations will be done monthly and recorded on all clients residing at Cornerstone to ensure that the deficient does not recur. To be completed by the Administrator and RSC.

Teresa Carpenter
9/3/08

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 18, 2008

Teresa Carpenter
Preferred Community Homes Cornerstone
615 2nd Avenue West
Wendell, Idaho 83355

RE: Preferred Community Homes Cornerstone, Provider #13G056

Dear Ms. Carpenter:

Enclosed is the form listing State licensure deficiencies from the Medicaid/Licensure survey of Preferred Community Homes Cornerstone, which was conducted on July 31, 2008. It is my understanding that some pages may have been missing from the original mailing.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Michael Case/se

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

MC/mlw

Enclosures

PRINTED: 08/14/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNER!	2028 EAST 2975 SOUTH WENDELL, ID 83355

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MM193	16.0311.075.10 Protection from Unwarranted Behavior Modifica Protection from Unwarranted Use of Behavior Modification Programs. Every resident admitted to the facility is to participate in behavior modification programs involving the use of restraints, timeout, or aversive stimuli only when the program: This Rule is not met as evidenced by: Refer to W278.	MM193	MM193 16.0311.075.10 PROTECTION FROM UNWARRANTED BEHAVIOR MODIFICATION Refer to W278 RECEIVED AUG 29 2008 FACILITY STANDARDS	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 16.03.11.075.10(a) APPROVAL OF HUMAN RIGHTS COMMITTEE Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM196 16.03.11.075.10(c) CONSENT OF PARENT OR GUARDIAN Refer to W263	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable	MM380	MM380 16.03.11.120.03(a) Building and equipment Toilet seat has been replaced. Dust covered vent has been cleaned. Toilet bolt covers will be replaced by 10/15/08. Handles on dresser will be replaced by 10/15/08. Utensil holder has been cleaned. Microwave has been cleaned.	

Bureau of Facility Standards

Teresa Carpenter Admin TITLE 8/25/08 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 08/14/2008
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MM380	Continued From page 1 precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - 6) residing in the facility. The findings include: An environmental review was conducted at the facility on 7/30/08 from 10:50 - 11:40 and the following concerns were noted: - There was a toilet seat in the medication room with an area of worn off paint approximately 8 inches in length creating a porous, un-cleanable surface. - There was a dust covered vent in the medication room. - The toilet bolt covers were missing from the toilets in the the bathroom shared by Individuals #1, #4 and #6. - There were no handles on Individual #5's dresser. - There was a utensil holder containing food debris on the kitchen counter. - There was a microwave in the kitchen with residual food on the top interior surface. - There were croutons and crumbs in the drawer under the oven.	MM380	Drawer under the oven has been cleaned. The facility will be kept clean and Sanitary and a monthly checklist Will be put into place to ensure the Facility will be kept clean, sanitary, And in good repair. To be completed by the RSC, and the Administrator by 10/27/08.	
MM520	16.03.11.200.03(a) Establishing and Implementing polices	MM520		

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MM520	Continued From page 2 The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W276.	MM520	MM520 16.03.11.200.03(a) ESTABLISHING AND IMPLEMENTING POLICIES Refer to W276	
MM573	16.03.11.210.05(e) Health Care Complaints Notation record of the individual resident's health care complaints and problems together with evaluation and action followed. This Rule is not met as evidenced by: Refer to W331.	MM573	MM573 16.03.11.210.05(e) HEALTH CARE COMPLAINTS Refer to W331	
MM575	16.03.11.210.06(a) Information in resident's record All information contained in a resident's record, including information contained in an automated data bank, will be considered confidential. This Rule is not met as evidenced by: Refer to W112.	MM575	MM575 16.03.11.210.06(a) INFORMATION IN RESIDENT'S RECORD Refer to W112	
MM678	16.03.11.250.08(c) Individual Resident's Needs Foods must be served in a form to meet individual resident's needs: This Rule is not met as evidenced by: Refer to W489.	MM678	MM678 16.03.11.250.08(c) INDIVIDUAL RESIDENT'S NEEDS Refer to W489 MM725 16.03.11.270.01(b) QMRP	
MM725	16.03.11.270.01(b) QMRP	MM725	Refer to W159	

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MM725	Continued From page 3 The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214 and W253.	MM730	MM730 16.03.11.270.01(d)(i) DIAGNOSTIC AND PROGNOSTIC DATA Refer to W214 and W253	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	MM735 16.03.11.270.02 HEALTH SERVICES Refer to W322	
MM740	16.03.11.270.02(b)(i) Interdisciplinary Evaluation In the continuing interdisciplinary evaluation of individual residents for the purposes of initiation,	MM740	MM740 16.03.11.270.02(b)(i) INTERDISCIPLINARY EVALUATION Refer to W168	

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MM740	Continued From page 4 monitoring, and follow-up of individualized habilitation programs; and This Rule is not met as evidenced by: Refer to W168.	MM740		
MM812	16.03.11.270.05(c)(ii)(f) Self Direction Self direction; and This Rule is not met as evidenced by: Refer to W239.	MM812	MM812 16.03.11.270.05(c)(ii)(f) SELF DIRECTION Refer to W239	
MM836	16.03.11.270.07 Physical and Occupational Therapy Services Physical and Occupational Therapy Services. Physical and occupational therapy services must be made available to any resident in need of such treatment. This Rule is not met as evidenced by: Refer to W218.	MM836	MM836 16.03.11.270.07 PHYSICAL AND OCCUPATIONAL THERAPY SERVICES Refer to W218	